SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Adult Sickle Cell Services Authorization Request Form

Patient Information

Patient's Name:	Today's Date:
Patient's Address:	Patient's DOB:

Service Information

(Information for Health Care Providers/Vendors | South Carolina Department of Public Health)

Requesting Physician:	Place of Service:	Requested Date of Service:

Service Requested: *(select box, enter amount)*

☐ Office Visit	☐ Low 99212 ☐ Moderate 99213 ☐ High 99214	Cost:
☐ Labs (select box that applies) If the code isn't listed, add below & add cost individually. Enter the total cost in the Total Amount Requested box.	☐ 36415 ($___) Routine venipuncture ☐ 80048 ($___) Metabolic Panel ☐ 80053 ($___) CMP ☐ 81001 ($___) Urinalysis ☐ 82043 ($___) Urine with Creatine ☐ 82248 ($___) Bilirubin ☐ 82306 ($___) Vitamin D ☐ 82570 ($___) 24hr Urine ☐ 82728 ($___) Ferritin ☐ 83020 ($___) Hemoglobin Elect. ☐ 83615 ($___) Lactate Dehydrogenase ☐ 82728 ($___) Hematocrit ☐ 83021 ($___) Hemoglobin Chrom. ☐ 84550 ($___) RBC Antibody Screen ☐ 85045 ($___) Retic Count ☐ 85025 ($___) CBC with diff ☐ 85027 ($___) CBC ☐ 84443 ($___) Thyroid ☐ 86850 ($___) RBC Antibody Screen ☐ 86900 ($___) Blood Typing ABO ☐ 86923 ($___) Type & Crossmatch ☐ 86901 ($___) Blood Typing RH ☐ 86902 ($___) Antigen Testing ☐ 73522 ($___) Bilateral Hip X-Ray	
	Code(s):	Cost:
CPT Code(s):		Cost:
☐ Special Request	CPT Code(s):	Cost:
☐ Other:		
☐ Medications:		
Total Amount Requested: $		

South Carolina Department of Public Health
Adult Sickle Cell Services Authorization Request Form

Instructions for Completing 4507-ENG-DPH

Purpose
This form is used by the outside medical provider or outside medical provider staff to request authorization for services for adult sickle cell clients served by the Children and Youth with Special Health Care Needs (CYSHCN) program. 4507-ENG-DPH may be used as a services request template, or the services request may be documented via the provider's own template.

Item-by-Item Instructions
Person submitting request will:

A. Patient Information
    1. Enter patient's name and today's date.
    2. Enter patient's address and patient's date of birth.
B. Service Information
    1. Enter requesting physician, place of service, and requested date of service.
    2. Enter service requested.
    3. Check office visit if applicable, associated code, and enter the cost of the visit.
    4. Check lab if applicable and check applicable lab tests and enter the cost of lab tests. If lab tests are not listed, write in the tests with the appropriate current procedural technology (CPT) codes and cost.
    5. Check special request if applicable, write in request, CPT code, and cost.
    6. Check other if applicable, write in request, CPT code, and cost.
    7. Check medication if applicable, list medications and cost.
    8. Enter total cost of all services requested.

Office Mechanics & Filing
This form should be filed in the comprehensive health record according to the current version of the health record format of the Health Record Policy Manual. The Comprehensive Health Records retention schedule, 08498, applies.